June 17, 2022

National Patient Advocate Foundation

Chiquita Brooks-LaSure
Administrator, Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Re: FY2023 Hospital Inpatient Prospective Payment System (IPPS) and Long Term Care Hospitals (LTCH PPS) Proposed Rule – CMS-1771-P

Dear Administrator Brooks-LaSure,

National Patient Advocate Foundation (NPAF) is pleased to submit feedback to the Centers for Medicare and Medicaid Services' FY2023 Hospital Inpatient Prospective Payment System (IPPS) proposed rule. We appreciate the Administration's leadership in working to advance health equity and address health care disparities in hospital inpatient care and beyond.

NPAF advocates for inclusive policies and practices that elevate patient and caregiver voices and put their perspectives at the heart of healthcare. Health equity forms the core of our person-centered agenda, which prioritizes health, financial and social stability as essential aspects of quality care. Our direct patient services counterpart, Patient Advocate Foundation (PAF), has delivered skilled needs navigation services specifically supporting social and financial well-being for over a million patients and families over its 25 years.

PAF works to identify and address individuals' unmet needs and overcome health system shortfalls that fail to account for the wide range of social and financial challenges faced by patients and their caregivers. Concern about the lack of these basic needs are frequent sources of distress and disparate outcomes among people coping with complex chronic conditions. According to survey data compiled by PAF, patients report financial distress as a top concern surpassing even the possibility of dying.

NPAF offers the following feedback regarding the rule's (1) proposal to adopt health equity-focused measures in the Hospital Inpatient Quality Reporting (IQR) program and (2) Request for Information on social determinants of health diagnosis codes.

Integrating effective interventions in the proposed health equity measures for the Hospital IQR Program

We appreciate CMS' intention of developing new measures – (1) Screening for Social Drivers of Health and (2) Screen Positive Rate for Social Drivers of Health – to promote adoption of screening for health-related social needs (HRSNs) and address health disparities. We commend CMS for encouraging hospitals to utilize screening as the basis for institution-specific action plans which could include navigation services.

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Most U.S. hospitals and physician practices do not have processes in place to discern or document patient and caregiver material hardships (food, utilities, housing insecurity), transportation barriers, and other financial or social challenges that would benefit from targeted intervention and safety net program supports.[1] In contrast, care settings that do provide these needs-based screenings and referral to specific financial and social supports have shown return on investment that includes increased treatment adherence, improved outcomes, and reduced overall costs for both patients and health systems. [2,3] We support health system adoption of HRSNs screening and acknowledge that flexibility regarding the specific screening tools will be important for productive implementation. To improve patient outcomes and begin minimizing health disparities, we urge CMS to consider measures that evaluate whether effective interventions are employed when patients screen positive.

Like the Accountable Health Communities (AHC) model launched by the Center for Medicare and Medicaid Innovation, our PAF navigators routinely screen patients who contact them by phone for household material hardships such as food insecurity, housing instability, transportation needs, and utility difficulties. Navigators follow up positive screens with a personalized intervention we call *needs navigation* which helps individuals and families navigate inherent health system complexities by connecting them to eligible government and community supports. Needs navigation, detailed in the attached issue brief (Appendix I), involves a range of services that meets people where they are and helps determine their most pressing financial and social concerns. Through this intervention, PAF helps limited-resourced individuals nationwide overcome financial and social barriers that impact health outcomes.

We recognize that the needs navigation field broadly includes professionals such as social workers who are consulted in hospital discharge planning where financial and social needs may be addressed. Unfortunately, the projected workforce shortage of social workers nationwide[4] and other health system pressures may impede equitable access to needs navigation in the hospital inpatient setting. Making high quality, skilled needs navigation services equitably and reliably available in all care settings will require federal government support and involvement. Hospitals can serve as one of many care settings where navigation services are offered to improve health and financial stability for patients and families, especially those living in underserved communities and medical professional shortage areas.

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[1] Fraze TK et al. Prevalence of Screening for Food Insecurity, Housing Instability, Utility Needs, Transportation Needs, and Interpersonal Violence by US Physician Practices and Hospitals. *JAMA Network Open*. 2019;2(9):e1911514

[2] Yezefski T, Steelquist J, Watabayashi K et al. Impact of Trained Oncology Financial Navigators on Patient Out-of-Pocket Spending. Am J Manag Care. 2018;24(5 Suppl):S74-S79

[3] Ell K, Vourlekis B, Xie B et al. Cancer Treatment Adherence among Low-Income Women with Breast or Gynecologic Cancer: A Randomized Controlled Trial of Patient Navigation. Cancer. 2009 October 1; 115(19): 4606–4615.

[4] Vernon W. Lin, Joyce Lin, Xiaoming Zhang, U.S. Social Worker Workforce Report Card: Forecasting Nationwide Shortages, *Social Work*, Volume 61, Issue 1, January 2016, Pages 7–15, https://doi.org/10.1093/sw/swv047

Challenges and opportunities for developing equitable and actionable SDOH diagnosis codes

We appreciate CMS efforts to gather feedback about SDOH diagnosis codes (Z codes) to advance health equity for all, including members of historically underserved and under-resourced communities. We agree that collecting accurate and consistent data about patients' socioeconomic circumstances will be an important first step to ensure hospitals can anticipate resource utilization. Research examining over 14 million hospital admissions found that while overall Z code utilization was less than two percent in 2016-2017, patients hospitalized with Z codes had disproportionately higher rates of mental health disorders including conditions related to drug and alcohol use.[5] Additionally, one study assessing fee-for-service Medicare beneficiaries found that in 2017, Z codes were more commonly recorded among beneficiaries who were younger, male, black, and Medicaid-enrolled.[6]

We caution that documenting and reporting Z codes may not always be the most appropriate way to meet people's needs and may perpetuate implicit bias surrounding race, ethnicity, insurance coverage, mental health and substance use disorders. The proposed rule notes that Z codes are currently reported voluntarily by providers when and if supported in the medical record documentation. The American Hospital Association recently published guidance that urges clinicians to incorporate patient's self-reported information into the medical record which can be used by coding professionals to document associated Z codes.[7] To build from this guidance, hospitals must be equipped with tools to communicate the context of Z codes with patients at the point of screening or self-reporting so that patients understand rationale for data collection and how it can help address their needs. Further upstream, the development and refinement of Z codes should involve robust patient engagement to ensure descriptors and screening questions resonate with populations that can benefit most from this data collection.

As CMS considers other data collection efforts for future rulemaking, we urge collection of data about the interventions, referrals, or services provided in response to positive SDOH screening. PAF collects data through internal issue codes that describe patients' financial and social needs along with resolution codes that describe interventions taken on behalf of patients. Notably, the top three resolution codes for insured patients in 2021 include (1) Utility Assistance: Utility financial relief obtained, (2) Housing Assistance: Located rental payment relief, and (3) Disability: Disability Education on Eligibility. This information helps to guide resource utilization and better understand patient needs and how to address them.

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[5] Truong HP et al. Utilization of Social Determinants of Health ICD-10 Z-Codes Among Hospitalized Patients in the United States, 2016-2017. *Med Care*. 2020;58(12):1037-1043. doi:10.1097/MLR.0000000000001418

[6] S.Y., Lester, C.M. *et al.* Use of Z-Codes to Record Social Determinants of Health Among Fee-for-service Medicare Beneficiaries in 2017. *J GEN INTERN MED* **35,** 952–955 (2020). https://doi.org/10.1007/s11606-019-05199-w

[7] American Hospital Association. ICD-10-CM Coding for Social Determinants of Health. Jan 2022. https://www.aha.org/system/files/2018-04/value-initiative-icd-10-code-social-determinants-of-health.pdf

Regarding protocols to standardize screening for SDOH, we recognize that some entities may leverage PRAPARE[8] and Health Leads' Social Needs Screening Toolkit[9] to provide frameworks for assessing patients' health-related social needs. We support flexibility among hospitals and staff to employ the tools that best work for their clinical workflow and patient populations.

Conclusion

NPAF appreciates the Administration's focus on improving health equity in the hospital inpatient setting. Providing needs navigation services directly to patients and caregivers and engaging them in research is a hallmark of PAF's two and a half decades of organizational experience, expertise, and history. We would be pleased to work with Administration offices and staff to discuss enhanced communication and patient engagement strategies that will assist hospitals in building trust with patients they serve. This will be especially important for hospitals serving patients in traditionally underserved communities, racial and ethnic minorities, and those who are not routinely engaged in health services research or care delivery reform.

We are happy to share lessons learned and welcome the opportunity to meet directly with Administration staff to discuss our input in these comments. Please contact Nicole Braccio at Nicole.Braccio@npaf.org or 202-301-9552 if we can provide further details.

Respectfully submitted,

Rebecca A. Kirch
EVP Policy and Programs

[8] NACHC. Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences. Available at: http://www.nachc.org/research-and-data/prapare/about-the-prapare-assessment-tool/
[9] The Health Leads Screening Toolkit. Available at: https://healthleadsusa.org/resources/the-health-leads-screening-toolkit/

APPENDIX I

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